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COMPARISON OF PATIENT AND SURGEON EXPECTATIONS FOR TOTAL HIP ARTHROPLASTY

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Purpose: Expectations of patients concerning total hip arthroplasty (THA) are related to willingness to undergo surgery and to later satisfaction. Analysis of discrepancies between patient and surgeon expectations before THA should lead to better understand motives of dissatisfaction about surgery, but this question has been seldom studied. Our objectives were to compare surgeons' and patients' expectations before THA, using the Hospital for Special Surgery Total Hip Replacement Expectations Survey (THR Survey) and to study factors which affect surgeon-patient agreement. **Methods:** Adult patients on waiting list for THA in three tertiary care centres were interviewed by phone, to assess their expectations and clinic-demographic characteristics. Surgeons used the same questionnaire to assess their expectations regarding the surgery of each patient. Patients' and surgeons' answers on THS questionnaire were compared, and differences between surgeons and patients scores were obtained. Univariate and multivariate analyses were used to test the effect of patients' characteristics on surgeon-patient differences.

Results: The three centres recruited 19 surgeons and 132 patients. Mean age was 62.8±13.7 years, 52% of patients were men. Indication for surgery was osteoarthritis in 82%, avascular necrosis in 12%. Surgeons' and patients' expectations scores were respectively 90.9±11.1 and 90.0±11.6 over 100. Mean surgeon-patient difference was close to zero, but surgeons' and patients' expectations scores showed little agreement on Bland and Altman graph and intraclass correlation coefficient was low (0.16). Patients expected better results than surgeons concerning exercise and sports. Patients with worse disability or physical quality of life, and patients with higher scores on trust in physician were likely to expect more than their surgeons and *vice versa*. Patients who were workers or employees were mostly more enthusiastic while patients who had a liberal, senior officer or intermediate occupation were mostly less enthusiastic. Patients with at least one comorbidity were mostly more enthusiastic, while patients with no comorbidity had mostly similar expectations than their surgeons.

Conclusions: Surgeons and patients do not agree on what to expect from THA, although there is no systematic bias between them. Patients with higher disability may have unrealistically high expectations.

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IMPAIRED KNEE STRENGTH BALANCE AND KNEE FUNCTION IN ADULTS WITH GENERALISED JOINT HYPERMOBILITY

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Purpose: Physical function is reported to be poor in adults with Benign Joint Hypermobility Syndrome (BJHS). The aim was to examine self-reported physical function and to measure knee strength balance in adults with Generalised Joint Hypermobility (GJH) and Non-GJH (NGJH).

Methods: Totally, 18 adults with GJH (mean age 40.1 years, SD 5.8), with a Beighton score of ≥4 and at least one hypermobile knee, and 18 adults with NGJH (mean age 40.3 years, SD 4.1), with a Beighton score of <4, no knee hypermobility and no knee pain, were included in a clinical test setting. Knee injury and Osteoarthritis Outcome Score (KOOS), physical fitness (VAS 0-100 mm) and general health were self-reported, and isokinetic concentric and eccentric knee flexion and extension strength at 60°/sec measured. Knee strength balance was calculated as hamstring/quadriceps (H/Q) ratios (Conventional and Functional). As a measure of general strength, maximum handgrip strength was further measured.

Results: Subjects with GJH reported significantly more knee-associated functional limitations in all domains of KOOS (pain, p=0.001; symptoms,

p=0.001; ADL, p=0.001; sport/recreation, p=0.003; knee-related quality of life, p<0.001), and poorer actual general health (p=0.04) compared to NGJH. Conventional concentric H/Q ratio was significantly lower in adults with GJH (0.46 vs. 0.54, p=0.046), together with a tendency towards lower normalised concentric knee flexion strength (0.88 Nm/kg vs. 1.03 Nm/kg, p=0.061), regardless of age and knee pain within the previous week.

Conclusions: In the present subjects with GJH we were able to demonstrate knee strength imbalance, which is a known risk factor for knee injury and early onset of secondary osteoarthritis. Consequently, exercises aimed at increasing muscle strength balance should be addressed to subjects with GJH, in order to prevent knee joint injury and early onset of osteoarthritis.

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HEALTH BELIEFS AND SELF-REPORTED OUTCOME AFTER MENISCECTOMY IN THE MIDDLE-AGED

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Purpose: Knee symptoms and functional limitations are common after meniscectomy in midlife. Both physical and psychological factors may influence the perceived functional limitations after knee injury. Inappropriate beliefs concerning joint health and exercise may be associated with passive coping strategies which may lead to a sedentary lifestyle. Self-efficacy of knee function is one psychological concept that has previously been found to be decreased in post meniscectomy patients. The purpose of the present study was to explore health beliefs related to physical activity and exercise in middle-aged post meniscectomy patients as well as the impact of health beliefs on self-efficacy of knee function, physical activity level and self-rated health.

Methods: 99 subjects (27% women) with median age 44.8 (IQR 6) years, who underwent an arthroscopic partial meniscectomy at median time 3 years earlier, answered questionnaires regarding beliefs related to joint health and exercise, family situation, education, height and body weight and smoking habits in addition to the Knee Self-Efficacy Scale (K-SES)(0-10), the Physical Activity Scale (PAS)(1-4) and a single item health rating (1-5).

Results: Median education length of the group was 13 (IQR 4) years, median Body Mass Index (BMI) was 26.4 (IQR 4) kg/m², 20% of the subjects were smokers. The median (IQR) values for K-SES was 7.4 (4), for PAS 2 (1) and for self-rated health 4 (1). 16% of the subjects (11% of the men and 29% of the women) thought that joint loading should be minimized after meniscectomy, and 7% of the subjects (8% of the men and 4% of the women) did not consider thigh muscle training to be important after meniscectomy. Subjects who believed that joint loading was not harmful after meniscectomy had better self-efficacy of knee function (p<0.001), higher PA level (p=0.04) and better health ratings (p=0.007) than those who thought that joint loading should be minimized. The majority of subjects believed that thigh muscle training was important after meniscectomy, and the remaining 6 persons did not differ from the others with respect to self-efficacy of knee function, physical activity level or self-rated health (p≥0.17). Preinjury participation in sports was positively associated with all three outcomes K-SES, PAS and self-rated health, $r_s = 0.33-0.42$, $P \leq 0.001$, while higher BMI was negatively associated with self-rated health, ($r_s = -0.35$, $P < 0.001$). Age or follow-up time since surgery was only weakly and non-significantly associated with the 3 outcomes but education length was positively associated with PAS ($r_s = 0.21$, $P \leq 0.035$). Smokers had similar results as non-smokers ($P > 0.10$).

Conclusions: Our results indicate that beliefs concerning joint health may have influence on self-efficacy of knee function, physical activity level and self-rated health after meniscectomy. Post meniscectomy patients should be taught about their knee condition and also be given advice about self-management techniques and appropriate exercise, in order to improve their knee function and increase their physical activity level as this may help to maintain good health.